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About the Plan

Medical Plan

Q. What is included in the AHS State Network (Network)?

A. You can receive the maximum benefits available under the Plan if you choose to receive care from providers who participate in the Network. Participating providers include a variety of physicians, hospitals, and medical service providers and facilities.

***Q.* Why should I choose to receive medical care from a Network provider?**

A. *Participating providers have agreed to accept pre-negotiated fees in exchange for their medical services. For you, this means that you are not responsible for any amounts over the allowable charge for covered services when you receive care from a participating provider.*

Q. How do I know if my doctor is participating in the Network?

A. To find a participating providers, go to "Find a Participating Provider" on the home page or contact Network at 800-294-6307.

Q. What is an out-of-network review?

A. This is the process of determining if the Plan will allow in-network level benefits for services provided by a non-participating provider. You should contact ActiveHealth at 866-939-4721 to request an out-of-network review.

Q. If the Plan is not my primary source of health benefit coverage, how does my insurance coverage work?

A. When a participant is covered by another group health plan, there may be some duplication in the coverage. To determine how the plans coordinate benefits, one is considered "primary" and the other is considered "secondary". How this is decided is called Coordination of Benefits.

Q. Where can I learn more about Coordination of Benefits?

A. To find out how to determine which of your plan coverage options are considered "primary" and which is considered "secondary", please refer to the Plan Document (PD). You can access the PD online under Publications.

B. When I reach age 65, will my Plan coverage coordinate with my Medicare coverage?

A. *Yes. The Plan will coordinate with Medicare to provide you health care benefit coverage. Refer to the PD for more information on coordination with Medicare.*

Q. What services require certification?

A. *To obtain certification, you will need to contact ActiveHealth. If you are scheduled to receive a certain type of medical service, you must contact ActiveHealth* ***in advance*** *to obtain certification. Services that require certification include:*

- *Inpatient hospital admissions*
- *Outpatient CAT Scan*
- *Outpatient MRI Scan*
- *Private duty and home health nursing services*
- *Solid organ and bone marrow/stem cell transplants*
- *Home infusion therapy services*
- *Skilled Nursing Facility*
- *Long Term Acute Care Facility*
- *Hospice Care*
- *Wound Vacuum Assisted Closure*
- *Diabetic self-management training/education*

For more complete details about what services must be certified, refer to the PD. You can access the PD under Publications.

Q. What kind of coverage does the Plan provide for medical care in an emergency situation?

A. Medical emergencies are unplanned events that may force you to seek prompt medical attention outside of the Plan's network of providers. In the case of certain emergency care situations, you may be eligible to receive in-network benefit coverage for emergency services rendered by a non-participating provider. For more information on emergency coverage levels and procedures, please consult the PD.

Prescription Drug Program

Q. What is a Preferred Drug List (PDL)?

A. *Catalyst Rx has a list of preferred brand name drugs. You receive a higher level of benefit coverage if you choose to fill your prescription with a preferred drug. You can access a list of preferred drugs by going to www.catalystrx.com or by contacting Catalyst Rx at 866-757-7839.*

Q. What is a generic drug?

A. *A generic drug has the same chemical equivalence (i.e., ingredients) of a brand-name or advertised drug. Under the Plan, you receive a higher benefit if you select a generic drug over a brand-name drug (when a generic drug is available).*

Q. What is a "non-preferred drug"?

A. *A "non-preferred drug" refers to those drugs that are available at the higher co-pay.*

Q. How can I find out if a drug is preferred?

A. *You can access a list of preferred drugs online by going to www.catalystrx.com or by contacting Catalyst Rx directly at 866-757-7839.*

Q. What mail service will be used for the Plan?

A. *As part of the prescription drug program, you can enjoy the convenience of home delivery by using the Catalyst Rx mail order service. You must register as a mail service customer before you can get a mail order prescription filled.*

Q. What levels of coverage are available to me under the prescription drug program?

A. *The following chart outlines prescription drug co-payments:*

	Co-payment Amounts	
	Retail Pharmacy (30-day supply)	Mail-Order (90-day supply)
Generic Drug	$12	$24
Preferred Brand Drug	$40	$80
Non-Preferred Brand Drug	$65	$130

In most instances, when a generic drug is available and the participant purchases the brand name drug, the participant will pay the difference in the cost of the brand name drug and the generic drug, plus the generic co-payment amount.

Based on the cost of some generic drugs, co-payment other than the generic co-payment may apply.

NOTE: Participants in Base Coverage will be charged the full allowable charge for each 30 day supply until the annual deductible is met.

Filing a Claim

Q. When do I need to file a medical claim?

A. *You need to file a claim when you receive care from a non-participating provider. Participating providers have agreed to file your claims for you. Before you can file a claim, you need to receive an itemized bill from your health care provider.*

Q. How do I file a medical claim?

A. *First, you must receive the proper itemized bill from your health care provider before you can file a claim. Then, you need to obtain a claim form from your personnel office or from Blue Cross & Blue Shield of Mississippi (BCBSMS). Be sure to read the instructions on the claim form carefully and complete the entire form to avoid delays in processing. Send your completed form to BCBSMS.*

Q. With whom do I file a medical claim?

A. *You should send your completed medical claim forms to:*

Blue Cross Blue Shield of Mississippi
P.O. Box 23071
Jackson, MS 39225-3071

Q. *How do I file a claim when the Plan is not my primary source of medical coverage?*

A. *First, file a claim with your "primary" plan and request an Explanation of Benefits (EOB) from that plan. Your second step is to file the claim with your "secondary" plan, which in this case is the State and School Employees' Health Plan. When you file with the Plan, please be sure to include a copy of your primary plan's EOB with your paperwork.*

If Medicare is your primary coverage, you would use this same claims filing process when filing for secondary coverage under the Plan.

Q. *How can I get a claim form?*

A. *You can obtain a claim form by contacting Blue Cross & Blue Shield of Mississippi.*

Q. *When do I need to file a prescription drug claim?*

A. *When you use a participating pharmacy, they will file a claim for you. You need to file a Direct Member Reimbursement form if you use a retail pharmacy that does not participate in the prescription drug program. You will need to keep your receipts from the pharmacy in order to file the claim.*

Q. *How do I file a prescription drug claim?*

A. *First, you will need to collect your receipt(s) from the retail pharmacy that does not participate in the prescription drug program. Then, you will need to obtain a Direct Member Reimbursement form by contacting Catalyst Rx or you can print a claim form at www.catalystrx.com. Be sure to read the instructions on the claim form carefully and complete the entire form to avoid delays in the processing. The completed form and attached receipt(s) should be mailed to Catalyst Rx.*

Q. *With whom do I file a prescription drug claim?*

A. *You should send your completed prescription drug claim forms to:*

Catalyst Rx
Direct Member Reimbursement
P O Box 1069
Rockville, MD 20849-1069

Q. *Is there a time limit for filing claims?*

A. *Yes, there is a deadline for filing medical and prescription drug claims. All claims must be filed with Blue Cross & Blue Shield or Catalyst Rx by the end of the calendar year following the year in which you received care.*

Q. *I would like to have a claim reviewed. How do I begin the appeals process?*

A. *You have 180 days to submit a written request for a review after receiving notice of denial from Blue Cross & Blue Shield of Mississippi or Catalyst Rx. If you do not request a review within this timeframe, you will lose your right to review. If you need more detailed information, you should refer to the Plan Document (PD). You can access the PD under Publications.*

Here Are Some Tips to Help You File Your Next Claim ....

- ✓ Keep all receipts from non-participating pharmacies and physicians.
- ✓ File your claim promptly.
- ✓ Use the correct form.
  (Remember, there are separate claim forms for medical and prescription drug benefits.)
- ✓ Complete the entire form.
- ✓ Make a copy of your completed form to keep for your own records.
- ✓ Mail the claim form to the correct address.

Coinsurance, Copayment and Deductibles

Q. What is a deductible?

A. *A deductible is the amount that you must pay each year before the Plan will begin to cover your health care expenses.*

Use this chart to find out what medical deductible(s) are for Select Coverage for 2010:

	IN-AREA PARTICIPANTS		OUT-OF-AREA PARTICIPANTS	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Calendar Year Deductible	$1,000	$2,000	$1,000	$2,000
Family Deductible	$2,000	$4,000	$2,000	$4,000

Use this chart to find out what the combined medical/pharmacy deductible(s) are for Base Coverage for 2010:

	In-Area Participants		Out-of-Area Participants	
	In-Network	***Out-of-Network***	***In-Network***	***Out-of-Network***
Calendar Year Deductible – Individual Coverage	$1,800		$1,800	
Calendar Year Deductible – Family Coverage	$3,000		$3,000	

Q. What is the difference between coinsurance and co-payments?

A. *Coinsurance is a percentage of the cost you pay for certain medical expenses, like doctors' visits. A co-payment is a flat fee you pay for expenses such as prescription drugs.*

Q. How can I be sure to get the most out of my benefit dollar?

A. *The Plan can provide you with the highest benefit coverage when you receive medical care from a participating provider; use an Catalyst Rx participating pharmacy; use the Mail Service for mail order prescriptions; and elect to fill your prescriptions using generic or preferred brand drugs, whenever possible.*

To get the most out of your benefit dollars, the Plan encourages you to:

- *Receive care from participating providers*
- *Certify appropriate medical services*
- *Choose to fill your prescriptions using generic or preferred brand drugs, whenever possible*
- *Visit a Catalyst Rx participating pharmacy to fill your prescriptions, or use the mail order service for maintenance medications*
- *File your claims promptly*